<b>Date Received</b>	in	Laboratory
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Laboratory Specimen Number

## COVID-19 (SARS-COV-2) ANTIBODY DETECTION Michigan Department of Health and Human Services

**Bureau of Laboratories** 

PO Box 30035 3350 North Martin Luther King Jr. Blvd. Lansing, MI 48909 Laboratory Records: 517-335-8059 Technical Information: 517-335-8067 PO Box 30035

Web: www.michigan.gov/mdhhslab Fax: 517-335-9871

Print in UPPERCASE using dark pen More Det	tailed Definitions/Explanations on page 2.		
SUBMITTER INFORMATION			
Submitter Information (Printed, Typed or Stamped)	Agency Code (If Known)  Telephone		
Submitter (Printed, Stan	Fax		
Contact Person/Ordering Physician/Provider Name	National Provider Identifier #		
PATIENT INFORMATION (Complete all fields)			
Name (Last, First, M.I.)			
Address	Apt. #		
City State Zip	Phone Number		
Submitter Patient # (if applicable) Symptomatic Yes \[ \] \	No		
Sex Race  Male American Indian or Alaska Native Female Native Hawaiian or other Pacific Islander	☐ Asian ☐ Black or African American ☐ White ☐ Other		
Ethnicity  Hispanic or Latino  Unknown  Date of Birth (MM-DI  Not Hispanic or Latino	D-YYYY) Pregnant (if known)		
SPECIMEN INFORMATION (Complete all fields)			
Onset Date (MM-DD-YYYY)  Collection Date (MM-DD-YYYY)  Collection Time (Military	/)		
Specimen Source Serum			
Vaccine Date (if applicable)			

## **DEFINITIONS/EXPLANATIONS**

**RETURN RESULTS TO:** Name and address of your institution (hospital, clinic, health department, state agency, etc.). Please include phone number and fax number.

PROVIDER: Name of the physician or provider authorized to order testing

**NATIONAL PROVIDER IDENTIFIER (NPI):** The NPI is a unique identification number for covered health care providers, must match with the name of the ordering party.

LABORATORY SPECIMEN NUMBER: For MDHHS Laboratory Use Only

**DATE COLLECTED:** The date (MM/DD/YYYY) that the specimen was collected from the patient.

**SPECIMEN SOURCE:** Serum is required.

PATIENT NAME: Patient's name (first and last). Must match specimen label exactly.

**DATE OF BIRTH:** Patient's date of birth (MM/DD/YYYY). Must match the specimen label exactly.

**SEX:** Mark the current biological sex of the patient. This may differ from gender or gender identity of patient.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

By Authority of Act 368, P.A. 1978